STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
IL6012470		B. WING		11/12/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
PITTSFI	ELD MANOR		RY STREET LD, IL 6236		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	DBE COMPLETE
S9999	Final Observations		S9999		
	Statement of Licens	sure Violation:			
	300.7020b)1)6)				
	Section 300.7020 A	Assessment and Care			
	focus (see Section of how the identified all and preferences will addressing the resid well-being; dignity, ouse of retained skills equipment; socialization others, communicated possible (verbal and personal expression exercise; and mean	an shall be ability centered in 300.7030) and shall define bilities, strengths, interests I be encouraged and used by dent's physical and mental choice, security, and safety; and abilities; use of adaptive ation and interaction with ion, on whatever level I nonverbal); healthful rest; a mbulation and physical ingful work.			
	followed by staff who	o care for the resident.			
**************************************	Based on record rev interview, the facilty individualized activity individual Activities A	view, observations and failed to revise and provide y care plans based on assessments for 4 of 4 (10, R11) reviewed for care ple of 12.			
Findings include:			Attachment	A	
; \	with E14, Licensed F Nurse, E10 Unit Dire	ring the initial tour of the Unit Practical Nurse LPN) Charge ector, no activities or leisure to be going on. On		Statement of Licensure	Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/01/15

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6012470 11/12/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 610 LOWRY STREET PITTSFIELD MANOR PITTSFIELD, IL 62363 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 11/4/2015 and 11/5/2015, during the noon meal, no other activities observed other than assisted dining for R5 and meal set up and independent dining for R3, R10 and R11. On 11/4/2015 and 11/5/2015, R3 observed either lying in bed or sitting in his chair bedside without activity participation. On 11/4/12015, 11/5/2015, 11/6/2015, R5 observed either in bed or visiting with family without facilty engaged activities. 2. R3's Activities Assessment, dated 9/28/2015, documented interests as collectibles, current events, dining out, current events, drawing, exercise/sports, helping others, movies, music, radio, reading/writing, talking/conversing/ trips/shopping, walking/wheeling outdoors and watching TV. R3's Care Plan, dated 9/30/2015, was not revised, individualized or documented to include problem, goal and approach(es) based on R3's Activities Assessment interests. 3. R5's Activities Assessment, dated 6/12/2015. documented interest as animals/pets, collectibles. cooking, crafts/arts, current events, dining out, exercise/sports, gardening/plants, helping others. movies, music, needlework, outdoor games. radio, reading/writing, spiritual/religious, talking/conversing, trips/shopping, walking/wheeling outdoors, watching TV and word games. R5's Care Plan, dated 3/4/2015, was not revised,

Assessment interests.

individualized or documented to include problem. goal and approach(es) based on R5's Activities

4. R10's Activities Assessment, dated 7/1/2015. documented interests as current events, dining

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Illinois Department of Public Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		, DETTI TOTAL OF THE MINER	A. BUILDING	-	00.7	CCICO
		IL6012470	B. WING		11/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			OTATE ZID OODE	1 11/1	2/2013
NAME OF	PROVIDER OR SUPPLIER		IRY STREET	STATE, ZIP CODE		
PITTSFII	ELD MANOR		LD, IL 6236			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From page	ge 2	S9999			
	radio, spiritual/religio walking/wheeling ou	ts, helping others, music, ous, talking/conversing, utdoors and watching TV.			:	
	R10's Care Plan, dated 10/20/14, was not revised, individualized or documented to include problem, goal and approach(es) based on R10's Activities Assessment interests. 5. R11's Activity Assessment, dated 7/15/2015, documented interests as animals/pets, collectibles, cooking, dining out, gardening/plants, helping others, movies, music, needlework, quilting, radio, reading/writing, spelling, spiritual/religious, talking/conversing, trips/shopping, walking/wheeling outdoors or watching TV.					
	revised, individualize	ated 5/11/2015, was not ed or documented to include pproach(es) based on R11's nt.			Andre 11 (CO ALCA RETRESPONDE DE LA COLOR	
		r, stated on 11/10/2015 at //2015 at 9:35AM, that "We n issues. We have				
And the state of t	Section 300.7030 Ab	oility-Centered Care	AMERICAN STATE OF THE STATE OF			
	activity-focused prog resident's abilities an planning. Tasks are provided for the resid maximum level of the centered care progra following concepts: a encountered and exc	are programming, also called ramming, recognizes the ad competencies in care adapted and modified to dent's involvement at the eresident's ability. Ability amming embraces the activities at every event, change with a staff member, other individuals; activities				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
			B W.10			
IL6012470		I	B. WING		11/1	2/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, RY STREET	STATE, ZIP CODE		
PITTSFI	ELD MANOR		LD, IL 6236			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S99 99	Continued From pa	ge 3	S9999			
	are redefined as; bo structured events a	oth independent and re used.				
	Section 300.7040 A	ctivities				
	a) The unit's activity ability-centered care	y program shall use e programming.				
	This standard is not	met as evidenced by:				
	Based on record review, observations and interview, the facilty failed to provide ability-centered care programming/activities for at least 8 hours a day for 7 days a week for 4 of 4 residents (R3, R5, R10, R11) reviewed for ability-centered care programming in the sample of 12.					
	Findings include:	WITTER BUILD AND AND AND AND AND AND AND AND AND AN				
	with E14, Licensed F Nurse, E10 Unit Dire activities were noted 11/4/2015 and 11/5/2 no other activities ob dining for R5 and me dining for R3, R10 at 11/5/2015, R3 obsersitting in his chair be participation. On 11/ 11/6/2015, R5 obsers	Practical Nurse LPN) Charge ector, no activities or leisure to be going on. On 2015, during the noon meal, eserved other than assisted eal set up and independent and R11. On 11/4/2015 and wed either lying in bed or dside without activity 14/12015, 11/5/2015, wed either in bed or visiting ecilty engaged activities.				
! :	Daily Program/Activit schedule consisted, i preakfast and lunch. afternoon/evening sc	Alzheimer's November 2015 by Schedule, the morning in part, "beautiful me", It was also noted that the chedule consisted, in part, of crubs and setting tables.				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1 ' '			LETED	
		IL6012470	B. WING		11/1	2/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
PITTSFI	ELD MANOR		RY STREET				
			LD, IL 6236	3		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY)	.D BE	(X5) COMPLETE DATE	
S9999	Continued From page	ge 4	S9999				
	11/5/2015 at 9:30AM was morning activiticonsisted of waking care. E13 did not pure assessment as to be assessed or incorporactivity for R3, R5, F3. R3's Activities As documented interest events, dining out, dexercise/sports, help radio, reading/writing	sessment, dated 9/28/2015, ts as collectibles, current					
	R3's Activity Participation Form, dated for month of 10-2015, was not individualized to include his specific interests or document that his participation in snacks, meals, family visits and back rubs were activity based not care based, activities of daily living, or how visitors were providing activities.						
i t	documented interest cooking, crafts/arts, exercise/sports, gard movies, music, need radio, reading/writing alking/conversing, traking/wheeling ouword games.	ips/shopping, tdoors, watching TV and					
i	of 10/2015 and 11/20 nclude her specific in	ation Form, dated for month 115, was not individualized to interests or document that nacks, meals, family visit and	TOTAL TOTAL CONTROL CO				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6012470	B. WING		11/12/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		-
PITTSFII	ELD MANOR		RY STREET LD, IL 6236			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE	
	back rubs were activativities of daily living providing activities. 5. R10's Activities Adocumented interes out, gardening/plant radio, spiritual/religio waling/wheeling outer R10's Activity Partici 10/2015, was not independent of the participation of the provided from the provide	vity based not care based, ng, or how visitors were assessment, dated 7/1/2015, ts as current events, dining s, helping others, music, ous, talking/conversing, doors and watching TV. pation Form, dated month of dividualized to include his that his participation in back rubs were activity based vities of daily living. assessment, dated 7/15/2015, as as animals/pets, dining out, gardening/plants, es, music, needlework, ng/writing, spelling, king/conversing, ng/wheeling outdoors or Activity Participation Form, 015, was not individualized to interests or that her as, meals and back rubs not care based, activities of of the Unit, undated, ere is no cure for the person ease, a therapeutic program of the unit, undated, ere is no cure for the person ease, a therapeutic program of the Unit, undated, ere is no cure for the person ease, a therapeutic program of the unit, undated to eacility where they will	S9999	DEFICIENCY)		
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STATE MENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			SURVEY
IL6012470		B. WING		11/1	2/2015	
NAME C	F PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PITTSI	FIELD MANOR		RY STREET LD, IL 6236			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
\$999	The facilty's Special and procedure, revise Special Care Unit is offers an ability/active for persons with Alzidisorder. The Special Care Unit is offers an ability/active for persons with Alzidisorder. The Special Care the programs after a have been completed 300.7050d) Section 300.7050 Stand Section 300.7050d) Section 300.7050 Stand Section 300.7050d Stand Section 300.7050 Stand Secti	I Care Programming policy sed 2-2012, documented "The a self-contained unit that vity-based approach to care heimer's disease or related ial Care Coordinator designs assessments on each person ed." taffing Certified Nursing Assistants), and activities staff who work on ercent of the time that they hall participate in a minimum is of orientation within the first yment, specifically related to with Alzheimer's disease and met as evidenced by: and record review, the facility 8 CNA's were provided 12 related to the care of persons hase and other dementia ployment of working on the arden Court Staff and Their I, documented E11, CNA, 06. Manual, not dated,	\$9999			
	orientation training wa		T-CHITCHARDALA			

	repartment of Fublic						
STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6012470	B. WING		11/·	12/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE			
PITTSFII	ELD MANOR		RY STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 7	S9999				
	1/14/2015.		Themso contained App				
,	11/10/2015 at 10:25 9:35AM, E11 did no	sing (DON), stated, on SAM and on 11-12-2015 at t have her 12 additional hours 45 days of employment.					
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